Empire BlueCross
An Anthem Company

Empire BlueCross Retiree Solutions Group Sponsored Health Plan Enrollment Election Form

All fields on this form are required

Group sponsor name: **Greater Amsterdam School District**	Group #: **NYEGR015**
Plan you will join: ☑ **Empire MediBlue Freedom (PPO) with Senior Rx Plus**	Requested effective date of coverage: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y) Generally the effective date of enrollment will be the first of the month following the enrollment receipt date, unless a future date is requested and is allowed.

FIRST name:	LAST name:	Middle initial:

Birthdate: (MM/DD/YYYY) (__ __/__ __/__ __ __ __)	Sex: ☐ M ☐ F	Phone number: ( ) ☐ Cell ☐ Other

Permanent residence street address (Do not enter a P.O. Box):

City:	State:	ZIP code:

Mailing address, if different from your permanent address (P.O. Box allowed):

Street address: City: State: ZIP code:

Email address: _____

Your email address will be used for communications only from Empire BlueCross Retiree Solutions. We will not share your email address.

Your Medicare information:

Medicare Number:

Please read and answer these important questions

1. Are you the retiree? ☐ Yes ☐ No

If "yes," retirement date (month/date/year): _____

If "no," name of retiree: _____ Retiree Medicare ID #: _____

2. Do you have other medical insurance? ☐ Yes ☐ No

If "yes," what is the name of the health plan (e.g., Aetna, Humana, Cigna)? _____

What are the effective dates of coverage? _____

3. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No

If "yes," please provide the following information:

Name of institution: _____

Address (number and street) and phone number of institution: _____

_____

How to qualify and enroll

How you qualify for this plan

To qualify for the Empire MediBlue Freedom (PPO) with Senior Rx Plus plan you must meet all of these conditions:

- You are a United States (U.S.) citizen or are lawfully present in the U.S.
- You live in the plan's service area.
- You are now entitled to Medicare Part A and enrolled in Part B.
- You keep paying your Medicare Part B premiums, unless they are paid by Medicaid or through another third party.
- You qualify for coverage under your or your spouse's group-sponsored health plan.

For more information on enrollment, call the **First Impressions Welcome Team** at **1-833-848-8729**, TTY: **711**, Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays. You can also visit **www.medicare.gov** to learn more about when you can sign up for a plan.

How to enroll

When you are ready to enroll, complete and mail the election enrollment form included in this guide.

What you need to complete the election enrollment form:

- Your Medicare Number (the number on your red, white and blue Medicare card). Fill out the requested information as it appears on your Medicare card. If required, also attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board and send it along with your completed enrollment election form.
- Your permanent address and phone number.
- You must complete all items listed on the enrollment election form. Complete and sign the enrollment election form that starts on the next page, and mail it to the address listed on it.

4. Will you have other prescription drug coverage (like VA or TRICARE) in addition to this plan? ☐ Yes ☐ No

Name of other coverage:	Member number for this coverage:	Group number for this coverage:

This document may be available in an alternate format, such as large print. Please call the First Impressions Welcome Team at **1-833-848-8729**, TTY: **711**, Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays, for additional information or questions you may have.

IMPORTANT: Read and sign below:

- I must keep Medicare Part A and Part B to stay in the plan I have selected.
- Release of information: By joining this Medicare Advantage Plan, I acknowledge that the plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Empire BlueCross Retiree Solutions will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable federal statutes and regulations.
- The information on this enrollment election form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my Empire MediBlue Freedom (PPO) with Senior Rx Plus coverage begins, I must get all of my medical and prescription drug benefits from Empire BlueCross Retiree Solutions. Benefits and services authorized by Empire BlueCross Retiree Solutions and contained in my Empire MediBlue Freedom (PPO) with Senior Rx Plus Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, neither Medicare nor Empire BlueCross Retiree Solutions will pay for benefits or services.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this enrollment election form means that I have read and understand the contents of this enrollment election form. If signed by an authorized representative (as described above), this signature certifies that:
    1) This person is authorized under state law to complete this enrollment election form, and
    2) Documentation of this authority is available upon request by Medicare.

Signature:	**Today's date:**
If you are the authorized representative, sign above and fill out these fields:	
Name:	Address:
Phone number:	Relationship to enrollee:

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HIPAA authorization

If you would like to authorize an individual to have the ability to speak with us and/or obtain protected health information (PHI) on your account, please complete the HIPAA (Health Insurance Portability and Accountability Act) Member Authorization Form on the next page, and **sign and return it with this form.** This form is valid for one year from the signature date.

- If you don't complete the HIPAA form at this time, a future request for this form can be made by contacting Member Services at the telephone number on the back of your membership card.
- If you wish to continue having the authorized representative on your account, a new form is required annually.
- If you have a durable health care power of attorney document, it can also be returned with the HIPAA form.

Please return this enrollment election form to:

Greater Amsterdam School District
Attn: Sarah Jones
140 Saratoga Avenue
Amsterdam, NY 12010

Please refer to the Empire BlueCross Retiree Solutions *Evidence of Coverage* for a complete listing of all plan benefits, conditions, limitations, and exclusions of coverage.

Our plan has free language interpreter services available to answer questions from non-English-speaking members. Please call the First Impressions Welcome Team number listed in this document to request interpreter services.

Empire BlueCross Retiree Solutions is an LPPO plan with a Medicare contract. Enrollment in Empire BlueCross Retiree Solutions depends on contract renewal. Empire BlueCross Retiree Solutions is the trade name of Anthem Insurance Companies, Inc. Independent licensee of the Blue Cross Blue Shield Association.